No. 5459 P. 1

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 03/31/2017 FORM APPROVED OMB NO. 0938-0391

AMAIL OF PROVIDER OR SUPPLIER QUALITY CARE HEALTH CENTER SITEST ADDRESS, CITY, STATE, ZIP CODE 932 BADDOUR PARKWAY LEBANON, TIN 37087 CR4) DP PREFIX REGULATORY OR LES IDENTIFING INFORMATION) K 000 INITIAL COMMENTS A Life Safety Code Survey was conducted by the State of Tennessee Department of Health Division of Health Licensure and Regulation Office of Health Care Fracilities survey on 03/27/2017. During this Life Safety Survey, Quality Health Center was found not in substancial compliance with the requirement for participation in Medicare/Medicald at 42 CFR Subpart 483.70(a), Life Safety from Fire, and the related National Fire Protection Association (NFPA) standard 101-2012. The requirement at 42 (CFR), Subpart 483.70(a) is NOTI MET as evidenced by: Means of Egress - General Alsies, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19-22. through 18/19-2. The continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19-2.2 through 18/19-2. The findings included: 1. Observation on 03/27/2017 at 10:01 AM, revealed the kitchen emergency egress door was obstructed by misc, storage, NFPA 101, 19.2.1 (2012 Edition) NFPA 01, 7.1, 10.1 (2012 Edition) 2. Observation on 03/27/2017 at 10:04 AM, feveraled the kitchen emergency egress door was obstructed by misc, storage, NFPA 101, 49.2.1 (2012 Edition) NFPA 01, 7.1, 10.1 (2012 Edition) 2. Observation on 03/27/2017 at 10:04 AM, feveraled the kitchen emergency egress door was obstructed by misc, storage, NFPA 101, 19.2.1 (2012 Edition) NFPA 017, 7.1, 10.1 (2012 Edition) 2. Observation on 03/27/2017 at 10:04 AM, feveraled on the content of th		l of deficiencies Of correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG 01 - MAIN BUILDING 01		TE SURVEY MPLETIED
STREET ADDRESS, CITY, STATE_ZIP CODE			445154	B. WING_			1071001 -
QUALITY CARE HEALTH CENTER REGILATORY OR LSS IDENTIFYING INFORMATION) REGILATORY OR LSS IDENTIFYING INFORMATION INFORMAT	NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	27/2017
FREERY TAG REGULATORY OR LSC IDENTIFYING INFORMATION) K 000 INITIAL COMMENTS A Life Safety Code Survey was conducted by the State of Tennessee Department of Health Division of Health Care Facilities survey on 03/27/2017. During this Life Safety Survey, Quality Health Center was found not in substancial compliance with the requirements for participation in Medicare/Medicald at 42 CFR Subpart 483.70(a) Life Safety from Fire, and the related National Fire Protection Association (NFPA) standard 101-2012. The requirement at 42 (CFR), Subpart 483.70(a) is NOT MET as evidenced by. K 211 SS=D Means of Egress - General Aisless, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of eall obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.1, 7.1.10.1 This STANDARD is not met as evidenced by. Based on observations, the facility falled to maintain the exits. The findings included: 1 Observation on 03/27/2017 at 10:01 AM, revealed the kitchen emergency egress door was obstructed by misc. storage, NFPA 101, 17.1.10.1 (2012 Edition) PREFX TAG ROSS-REFERENCE CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) All Life Safety Code Survey was conducted by the Old Requiring obstructing gress was removed by the Director of Maintenance, destroin: The Miscellaneous storage obstructing gress was removed by the Director of Maintenance, destroin: The Miscellaneous storage obstructing dries as removed by the Director of Maintenance, destroin: The Miscellaneous storage obstructing dries as removed by the Director of Maintenance, destroin: The Miscellaneous storage obstructing dries and twas Inserviced by the Director of Maintenance, destroin: The Miscellaneous storage obstructing gress scondary score it agrees are the recuted there were no residents with potential to be affected: The facility determined there were no residents that have the presidents with po	QUALITY	Y CARE HEALTH CEN	TER		932 BADDOUR PARKWAY		
A Life Safety Code Survey was conducted by the State of Tonnessee Department of Health Division of Health Licensure and Regulation Office of Health Care Facilities survey on 03/27/2017. During this Life Safety Survey, Quality Health Center was found not in substancial compliance with the requirements for participation in Medicare/Medicald at 42 CFR Subpart 483.70(a), Life Safety from Fire, and the related National Fire Protection Association (NFPA) standard 101-2012. The requirement at 42 (CFR), Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 Means of Egress - General K 211 SS=D Means of Egress - General K 221 The requirement at 42 (CFR), Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 Means of Egress - General Means of Egress - General K 211 Means of Egress - General K 221 The requirement at 42 (CFR), Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 Means of Egress - General K 221 K 221 The requirement at 42 (CFR), Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 Means of Egress - General K 221 K 221 The requirement at 42 (CFR), Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 Means of Egress - General Means of Egress - General K 221 K 221 C 221 MET A C CFR (A C CFR) (A C	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	(X5) COMPLETION DATE
Division of Health Cicensure and Regulation Office of Health Care Facilities survey on 03/27/2017. During this Life Safety Survey, Quality Health Center was found not in substancial compliance with the requirements for participation in Medicare/Medicald at 42 CFR Subpart 483.70(a). Life Safety from Fire, and the related National Fire Protection Association (NFPA) standard 101-2012. The requirement at 42 (CFR), Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. This STANDARD is not met as evidenced by: Based on observations, the facility falled to maintain the exits. The findings included: 1. Observation on 03/27/2017 at 10:01 AM, revealed the kitchen emergency egress door was obstructed by misc. storage. NFPA 101, 19.2.1 (2012 Edition) NFPA 101, 7.1.1.0.1 (2012 Edition)	K 000	A Life Safety Code	Survey was conducted by the	K 00	Corrective Action: The Miscellaneous storestructing egress was removed by the l	Pirector of	4/27/17
K 211 SS=D Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.1.1 This STANDARD is not met as evidenced by: Based on observations, the facility falled to maintain the exits. The findings included: 1. Observation on 03/27/2017 at 10:01 AM, revealed the kitchen emergency egress door was obstructed by misc. storage. NFPA 101, 19.2.1 (2012 Edition) NFPA 101, 7.1.10.1 (2012 Edition) K 211 Alapropriate egress for the purpose of identifying other potential obstructed egresses affecting resident's safety. Other exit egress steps will be checked by the ADM or designee in the purpose of chentrifying other potential obstructed egresses affecting resident's safety. Other exit egress steps will be checked by the ADM or designee in the purpose of chentrifying other potential obstructed egress steps will be checked by the ADM or designee in the purpose of chentrifying other potential obstructed egress teps will be checked by the ADM or designee in the purpose of ensuring they meet exit requirements. Measures or Systemic Changes: The miscellaneous storage obstruction the kitchen exit door has been relocated to another area in the kitchen exit door has been posted indicating no storage allowed to obstruct egress by the Director of Maintenance. The exit door area will be added to the Kitchen egress to meet the exit door will be checked by the Director of Dietary or designee. A secondary step was added to the kitchen egress to meet the exit door will be checked by the ADM or designee 1x week x 4 weeks and then monitored: The exit door will be checked by the ADM or designee 1x week x 4 weeks and then monitored: The exit door will be checked by the ADM or		Division of Health L Office of Health Car 03/27/2017. During Quality Health Cent substancial complia participation in Med Subpart 483.70(a), related National Firs (NFPA) standard 10 The requirement at	icensure and Regulation re Facilities survey on this Life Safety Survey, er was found not in ince with the requirements for icare/Medicald at 42 CFR Life Safety from Fire, and the Protection Association 11-2012.		designee on keeping egress unobstructe clear of storage. The kitchen emergency step had a secondary concrete step adde exit requirements by the Director of Mai identifying other residents with potentiaffected: The facility determined there residents that have the potential to be a there are no residents that exit from the However, other egress areas in the facilit the potential to affect other residents if a egresses are obstructed. The exit doors facility will be checked by the ADM or de	t and exit egress d to meet ntenance. al to be vere no fected as kitchen, y have he n the signee for	
revealed the step outside the kitchen emergency BORATURY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE	SS=D	MEPA 101 Means of Means of Egress - C Aisles, passageways exit locations, and a with Chapter 7, and continuously maintafull use in case of er 18/19.2.2 through 18 18.2.1, 19.2.1, 7.1.1 This STANDARD is Based on observation maintain the exits. The findings include 1. Observation on 03 revealed the kitchen obstructed by misc. (2012 Edition) NFPA 2. Observation on 03 revealed the step our evealed the step our	Fegress - General General Seneral Seneral Seneral Seneral Secondary Se	•	other potential obstructed egresses affer resident's safety. Other exit egress steps checked by the ADM or designee for the of ensuring they meet exit requirements. Measures or Systemic Changes: The miss storage obstructing the kitchen exit door relocated to another area in the kitchen a has been posted indicating no storage all obstruct egress by the Director of Maintel The exit door area will be added to the Kitchen exit door area will be added to the Kitchen egress to meet the of Dietary or designee. A secondary step added to the kitchen egress to meet the erequirements by the Director of Mainten: How corrective action will be monitored door will be checked by the ADM or designee will review the audits are findings to the QAPI committee. The QAPI committee will review the results at the Committee will review the POC was effective.	ting will be purpose dellaneous has been and a sign owed to nance, tchen Director was exit ince. The exit hee 1x nths. The d report	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION 101 - MAIN BUILDING 01	(X3) DATE	<u>0938-0391</u> E SURVEY PLETED
		445154	B, WING		03/	27/2047
	PROVIDER OR SUPPLIER Y CARE HEALTH CEN		2	STREET ADDRESS, CITY, STATE, ZIP CODE 132 BADDOUR PARKWAY LEBANON, TN 37087	<u>1 (3),</u>	<u>27/2017</u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 211	egress door exceed for a step in the me 19.2.1 (2012 Edition (2012 Edition) Maintenance staff with deficiencies were id acknowledged the conference on 03/2	ted the maximum riser height ans of egress. NFPA 101, 101, 101, 101, 101, 101, 101, 101	K 211	Corrective Action: The padlock to the outs green gate was removed by the Director o Maintenance and the staff was inserviced ADM or designee on the need and require no double lock on egresses and power mailocks must release upon activation of the falarm system. The 2 doors beside the Sounurse station were repaired by contractor release upon fire alarm activation. Identifying other residents with potential	f by the ment for gnetic ire th 1&2	4/27/17
SS≅F	Egress Doors Doors in a required equipped with a late use of a tool or key using one of the following one of the following one of the following one locking the each door and proving a locking one locking of all key all times; or other suffer the staff at all time 18.2.2.2.5.1, 18.2.2.2 SPECIAL NEEDS 10 Where special locking safety needs of the political or Security Leing met. In additional electrical locks that the upon loss of power the protected by a super	means of egress shall not be h or a lock that requires the from the egress side unless owing special locking OR SECURITY THREAT og arrangements for the is of the patient are used, ice shall be permitted on sions shall be made for the upants by: remote control of ocks or keys carried by staff at ch reliable means available as. 2.6, 19.2.2.2.5.1, 19.2.2.2.6 OCKING ARRANGEMENTS ag arrangements for the patient are used, all of the ocking requirements are not the locks must be all safely so as to release to the device; the building is vised automatic sprinkler and space is protected by a	K 222	affected: The facility determined that any residents utilizing the courtyards one either the gate with pad lock would have the potential gate with pad lock would have the potential to be affected and any residents in or around South I & II nurses station or on the unit has would have the potential to be affected. Go were checked by the Director of Maintenant the purposes of ensuring no double locking mechanisms were present. Exit doors were by the Director of Maintenance during fire activation for the purpose of ensuring the parapetic locks released upon activation. Measures or Systemic Changes: The pad to the green gate was removed by the Director Maintenance and checking gates for double locking mechanisms will be added to the Maintenance Checklist to be performed by Director of Maintenance or designee. Testif power magnetic lock doors will be added to fire drill procedures to be performed by the Director of Maintenance or designee. How corrective action will be monitored: The gates will be checked by the ADM or design week x 4 weeks then monthly for 2 months doors with magnetic power locks will be checked by the ADM or designed 1x month x 3 month The ADM or designed will review the audits report findings to the QAPI committee. The committee will review the results at the QA meeting to ensure the POC was affective an further corrective action is warranted.	ential to the dis distes nce for e tested alarm nower or of the ing the the the the could be the the the the the the the the the th	

STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1), PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY MPLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	within the locked s and detection systedoors upon activat 18.2.2.2.5.2, 19.2 DELAYED-EGRES ARRANGEMENTS Approved, listed do installed in accordance in throughout by an affire detection system automatic sprinkle 18.2.2.2.4, 19.2.2 ACCESS-CONTRO ARRANGEMENTS Access-Controlled installed in accordance with 7. door assemblies in by an approved, sudetection system a automatic sprinkle 18.2.2.2.4, 19.2.2.2 ELEVATOR LOBB ARRANGEMENTS Elevator lobby exit accordance with 7. door assemblies in by an approved, sudetection system a automatic sprinkler 18.2.2.2.4, 19.2.2.2 This STANDARD in Based on observal maintain the egress. The finding include 1. Observation on 3.	red at an attended location space); and both the sprinkler ems are arranged to unlock the tion. 2.2.5.2, TIA 12-4 GS LOCKING Selayed-egress locking systems ance with 7.2.1.6.1 shall be assemblies serving low and entents in buildings protected approved, supervised automatic em or an approved, supervised r system. 2.4 OLLED EGRESS LOCKING Selaces Door assemblies ance with 7.2.1.6.2 shall be access door locking in 2.1.6.3 shall be permitted on a buildings protected throughout approvised automatic fire and an approved, supervised r system. 2.4 is not met as evidenced by: tions, the facility failed to s doors. d: 8/27/17 at 9:40 AM, revealed	K	222			
ĺ	smoking area padk	een) leading out of the ocked with no key. NFPA 101,					

MAME OF PROVIDER OR SUPPLIER QUALITY CARE HEALTH CENTER STREET ADDRESS, GITY, STATE, ZIP CODE 932 BADDOUR PARKWAY LEBANON, TN 37087 LEBA		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i .		E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DAT	E SURVEY
MAKE OF PROVIDER OR SUPPLIER QUALITY CARE HEALTH CENTER SUMMARY STATEMENT OF DEFICIENCIES 32 BADDOUR PARKWAY			AARARA		-	OF THAM BUILDING UT		II DALLE
QUALITY CARE HEALTH CENTER SUMMARY STATEMENT OF DEFICIENCY SINCE CARL DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION REGULATORY OR LSC IDENTIFY INFORMATION REGULATORY OR LSC IDENTIFY IN	NAME OF I	PROVIDER OR SHIPPING	445154	B, WING	_		03/	27/2017
REGULATORY OR LSC IDENTIFYING INFORMATION REGULATORY OR LSC IDENTIFYING INFORMATION K 222 Continued From page 3 19.2.1 (2012 Edition) NFPA 101, 7.2.1.5.3 (2012 Edition) 2. Observation and festing during the fire drill on 3/27/17 at 11:51 AM, revealed the magnetic power locks (2 of 2) did not release on fire alarm activation located beside the South 1&2 nurse station. NFPA 101, 19.2.1 (2012 Edition) The maintenance director was present when this deficiency was identified and was acknowledged by the administrator during the exit conference on 3/27/17. K 293			TER		9	32 BADDOUR PARKWAY		
19.2.1 (2012 Edition) NFPA 101, 7.2.1.5.3 (2012 Edition) 2. Observation and testing during the fire drill on 3/27/17 at 11:51 AM, revealed the magnetic power locks (2 of 2) did not release on fire alarm activation located beside the South 182 nurse station. NFPA 101, 19.2.1 (2012 Edition) NFPA 101, 7.2.1.6.1 (2012 Edition) NFPA 101, 7.2.1.6.1 (2012 Edition) The maintenance director was present when this deficiency was identified and was acknowledged by the administrator during the exit conference on 3/27/17. K 293 SS=D Exit Signage 2012 ExiSTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This STANDARD is not met as evidenced by: Based on observations, the facility failed to maintain the exit signage. The finding included:	PREFIX	! (EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF		(FACH CORRECTIVE ACTION SHOULD GROSS-REFERENCED TO THE APPROPH	BE	(X5) COMPLETION DATE
Observation on 03/27/2017 at 10:55 AM, revealed the exit sign located at the cross corridor door by room 56, south nurses station and by the conference room did not direct towards the nearest exit. NFPA 101, 19.2.10.1 (2012 Edition) NFPA 101, 7.10.6.2.1 (2012 Edition) NFPA 101, 7.10.6.2.1 (2012 Edition)	K 293 SS=D	19.2.1 (2012 Edition Edition) 2. Observation and 3/27/17 at 11:51 AM power locks (2 of 2) activation. NFPA 101, 101, 7.2.1.6.1 (2012) The maintenance dideficiency was identiby the administrator 3/27/17. NFPA 101 Exit Signal Exit Signage 2012 EXISTING Exit and directional accordance with 7.1 also served by the editional secondance with 7.1 also seco	testing during the fire drill on I, revealed the magnetic did not release on fire alarm eside the South 1&2 nurse 19.2.1 (2012 Edition) NFPA Edition) rector was present when this lifed and was acknowledged during the exit conference on age signs are displayed in 0 with continuous illumination mergency lighting system. story existing occupancies cupants where the line of exit not met as evidenced by: ons, the facility failed to nage. 17/2017 at 10:55 AM, revealed at the cross corridor door by es station and by the inot direct towards the lot, 19.2.10.1 (2012 Edition)			Corrective action: The exit sign located at the cross corridor door by room 55, south nurse station and by the conference room were corrected by the Director of Maintenance that towards the nearest exit. The staff was insubject towards nearest exit. The staff was insubject towards nearest exit. It is staff was insubject towards nearest exit. It is staff was insubject towards nearest exit. It is facility determined that any residents in the exit path near or around the corridor by room 55, south nurse station are conference room have the potential to be affected. Exit signs were checked by the Director. Exit signs were checked by the Director. Exit signs were checked by the Director of Maintenance for the purpose of ensuring signs direct towards the nearest exit. Measures or Systemic changes: Checking exit of direction towards nearest exit will be active Maintenance Checklist to be performed Director of Maintenance or designee. How corrective action will be monitored: The Maintenance of the QAPI committee will review the results QAPI meeting to ensure the POC was effect.	co direct serviced se	4/27/17

STATEMENT AND PLAN (OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DAT	F, SURVEY IPLETIED
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NAME OF	PROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE	03/	27/2017
QUALIT	CARE HEALTH CEN	TER			32 BADDOUR PARKWAY EBANON, TN 37087		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BČ	(X6) COMPLETION DATE
K 293 K 321 SS=D	deficiencies were id acknowledged the deconference on 03/2 NFPA 101 Hazardon Hazardous Areas - 2012 EXISTING Hazardous areas at having 1-hour fire referenced doors) or a system in accordance approved automatic option is used, the acother spaces by sm doors in accordance self-closing or autor have nonrated or fie that do not exceed at the door. Describe the floor a hazardous areas that 19.3.2.1 Area Separation N/A a. Boiler and Fuel-Fb. Laundries (larger c. Repair, Maintenant conference of the self-closing or autor have nonrated or fie that do not exceed at the door. Describe the floor a hazardous areas that 19.3.2.1	vas present when the lentified and the administrator deficiencies during the exit 7/2017. us Areas - Enclosure Enclosure re protected by a fire barrier esistance rating (with 3/4-hour an automatic fire extinguishing ce with 8.7.1. When the fire extinguishing system areas shall be separated from oke resisting partitions and e with 8.4. Doors shall be matic-closing and permitted to eld-applied protective plates 48 inches from the bottom of at are deficient in REMARKS. Automatic Sprinkler ired Heater Rooms than 100 square feet) ince, and Paint Shops ms (exceeding 64 gallons) Rooms ins) age Rooms/Spaces		293	K321 – Hazardous Areas – Enclosure Corrective action: The penetration around metal exhaust vent in the boller room was using the appropriate fire stopping system Director of Maintenance under the supervia a consultant certified in fire stop systems, laundry door was repaired by Director of Maintenance and contractor by adjusting the closing device as well as adding spring hing staff was inserviced by the ADM or designe regarding fire penetrations and the need for laundry door to close properly. Identifying other residents with potential affected: The facility determined that all rehave the potential to be affected. Other bo rooms and mechanical rooms will be check the Director of Maintenance or designee and identified penetration sealed with the apprifire stopping system under the supervision consultant certified in fire stop systems. Fire/Smoke doors will be checked by the Director of Maintenance for required closure and an issues identified will be repaired by the Director of Maintenance or designee. Measures or Systemic Changes: Looking for penetrations will be added to the Maintenance Checklist to be performed by the Director of Maintenance or designee as well as checkling doors for the required closure. How corrective action will be monitored: To boiler rooms and mechanical rooms will be checked by the ADM or designee 1x week x weeks then monthly for 2 months. The ADM designee will review the audits and report to findings to the QAPI committee. The QAPI	sealed by the slon of The he self- es. The e to be esidents ller ed by nd any opriate of a rector ny ector of r fire ince if he A or the	4/27/17
	This STANDARD is Based on observati	not met as evidenced by: on the facility failed to			committee will review the results at the QA meeting to ensure the POC was effective ar further corrective action is warranted.		

		I WEDICAID SERVICES			OMB NO.	<u>_0</u> 938-039		
STATEMEN AND PLAN (TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G 01 - MAIN BUILDING 01		F SURVEY		
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QUALITY	PROVIDER OR SUPPLIER Y CARE HEALTH CEN	DER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP COD				03/27/2017 =		
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K 321	Continued From pa maintain hazardous The findings include	ed;	K 32	1				
	revealed a penetrat exhaust vent in the supply. NFPA 101, to 2. Observation on 3 the commercial laur	/27/17 at 1:00 PM, revealed ndry door (washer side) did the frame, NFPA 101,						
K 324 SS=E	deficiencies were id acknowledged the conference on 03/2 NFPA 101 Cooking Cooking Facilities Cooking Facilities Cooking equipment with NFPA 96, Standard Fire Protection Operations, unless: * residential cooking appliances such as toasters) are used for cooking in accordance.	Facilities is protected in accordance dard for Ventilation Control of Commercial Cooking equipment (i.e., small microwaves, hot plates, or food warming or limited ce with 18.3.2:5.2:19:3.2:5.2:	K 324	K324 – Cooking Facilities Corrective action: The rooftop hood shath has been removed by contractor and the exhaust hood cover has been secured on the assembly by the Director of Mainten identifying other residents with potential affected: The facility determined that all have the potential to be affected, however is no other potential areas to be affected grease build up as there is only 1 kitchen Measures or Systemic changes: Checking kitchen hood for grease build up and the cover securement will be added to the Maintenance Checklist to be performed.	e rooftop operly to ance. al to be I residents ver, there i with hood. g the	4/27/17		
	* cooking facilities of compartments with a with the conditions of cooking facilities in 30 or fewer patients 18.3.2.5.4, 19.3.2.5. Cooking facilities processing facilities processing facilities processing facilities and cooking facilities processing facilities pr	pen to the corridor in smoke 30 or fewer patients comply under 18.3.2.5.3, 19.3.2.5.3, smoke compartments with comply with conditions under		Director of Maintenance or designee. How corrective action will be monitored hood and the hood cover will be check be or designee 1x week x 4 weeks and then for 2 months. The ADM or designee will the audits and report the findings to the committee. The QAPI committee will revesults at the QAPI meeting to ensure the effective and if any further corrective act warranted.	I; The y the ADM monthly review QAPI rlew the			

STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	1		E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		445154	B. WING			03/	27/2017
!	PROVIDER OR SUPPLIER Y CARE HEALTH CEN	ITER		9	TREET ADDRESS, CITY, STATE, ZIP CODE 32 BADDOUR PARKWAY EBANON, TN 37087	1	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
K 324	corridor.	ut shall not be open to the	K	324			
	This STANDARD is Based on observat protect the cooking	s not met as evidenced by: ions, the facility failed to equipment.					
	The findings iniclud	ed:			; -		
	excessive grease b shaft grate. NFPA 1	/27/17 at 11:36 AM, revealed uildup on the rooftop hood 01, 19.3.2.5.1 (2012 Edition) 012 Edition) NFPA 96, 11.6.2*				,	
	the rooftop exhaust properly to the asse	/27/17 at 11:39 AM, revealed hood cover was not secured mbly. NFPA 101, 19.3.2.5.1 \(^101, 9.2.3 (2012 Edition) \(^2 Edition)					
K 345 SS=D	these deficiencies warministrator later a deficiencies during t 3/27/17.	rector was present when vere identified and the cknowledged these the exit conference on n System - Testing and	КЗ	45			
	A fire alarm system accordance with an	Testing and Maintenance is tested and maintained in approved program complying ts of NFPA 70, National				•	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DAT	E SURVEY PLETED
		445154	B. WING	;		03/	27/2017
	PROVIDER OR SUPPLIER Y CARE HEALTH CEN	TER		9	TREET ADDRESS, CITY, STATE, ZIP CODE 32 BADDOUR PARKWAY LEBANON, TN 37087	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	COMPLETION DATE
K 345	and Signaling Code	NFPA 72, National Fire Alarm Records of system Enance and testing are readily	K	345	K345 ~ Fire Alarm System ~ Testing / Main: Corrective action: The smoke detectors in corridor by the conference room, A&B closs and corridor behind Administrative offices been moved by contractor to an area outsifeet of air flow. Identifying other residents with potential affected: The facility determined that any	the ik room have de of 3 : to be	4/27/17
	Based on observation maintain the smoke. The finding included Observation on 3/27 revealed smoke detairflow in the following a corridor by the color. A&B clock in room c. corridor behind ac 101, 19.3.4.5.1 (201)	d: 7/17 at 9:11 AM- 10:00AM, tectors within three (3) feet of ng locations: onference room			residents near or around smoke detectors that a not outside of 3 feet from air flow have the potential to be affected. Smoke detectors will be checked by the Director of Maintenance to ensuthey are not within 3 feet of air flow. Any additional smoke detectors identified within 3 feet of air flow will be moved by contractor. Measures or Systemic changes: Any smoke detectors found to be within 3 feet of air flow with moved by contractor. How corrective action will be monitored: The QAPI committee will review the results at the QA meeting to ensure the POC was effective and if a further corrective action is warranted.		
SS≃D	deficiency was ident by the administrator 3/27/17. NFPA 101 Sprinkler Testing Sprinkler System - N Automatic sprinkler inspected, tested, ar with NFPA 25, Stand Testing, and Maintai	irector was present when this tifled and was acknowledged during the exit conference on System - Maintenance and Maintenance and Testing and standpipe systems are not maintained in accordance dard for the Inspection, ining of Water-based Fire Records of system design, oftion and testing are	Кз	53			

STATEMENT AND PLAN (FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION 61 - MAIN BUILDING 01		E SURVEY PLETED
		445154	B, WING			03/	27/2017
	PROVIDER OR SUPPLIER Y CARE HEALTH CEN	TER		8	TREET ADDRESS, CITY, STATE, ZIP CODE 32 BADDOUR PARKWAY EBANON, TN 37087	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFI TAG	X ·	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RE	(X5) COMPLETION DATE
K 353	maintained in a sec available. a) Date sprinkler s b) Who provided s c) Water system s Provide in REMARK any non-required or system. 9.7.5, 9.7.7, 9.7.8, a This STANDARD is Based on observation and the since in the since in the sidewall position of the sidewall position	ystem last checked ystem test upply source (S information on coverage for partial automatic sprinkler and NFPA 25 ont met as evidenced by ions, the facility failed to er system. (d: 3/27/2017 at 10:05 AM, and pendant sprinkler installed on in the ICF kitchen outside A 101, 19.3.5.1 (2012 Edition) 2012 Edition) NFPA 13, and cardboard boxes under the exit across from the m without sprinkler coverage. (2012 Edition) NFPA 101, and NFPA 13, 8.15.7.5 (2010) as present when the entified and the administrator efficiencies during the exit 7/2017.	K 3		K353 – Sprinkler System – Maintenance / T Corrective Action: The downward sprinkler the sidewall of the ICF kitchen closet has be replaced by a contractor with an appropria sprinkler head. The cardboard boxes unde canopy outside of the exit across from Phys. Therapy have been removed by the Director Maintenance. Staff was inserviced by ADM designee on not storing under the canopy of Identifying other residents with potential affected: The facility determined that no re had the potential to be affected by the spring head in the outside kitchen storage room a residents near or around the canopy area of the exit across from Physical Therapy or an residents outside under the canopy area ha potential to be affected. Sprinkler heads in will be checked by the Director of Maintena designee for appropriate heads. The canop will be checked for storage and a sign poste the ADM or designee indicating there is no allowed in that area. Measures or Systemic changes: Any sprinkl heads identified to be the incorrect type wi replaced by contractor with the appropriate Checking the canopy area will be added to t Maintenance Checklist to be performed by Director of Maintenance or designee. How corrective action will be monitored: T canopy area will be checked by the ADM or designee 1x week x 4 weeks and then mont 2 months. The ADM or designee will review and report findings to the QAPI committee. QAPI committee will review the results at the meeting to ensure the POC was effective an further corrective action is warranted.	r head in een te r the sical or of or	4/27/17

No. 5459 P. 17

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY, PLETED
		445154	B. WING			03/2	27/2017
	PROVIDER OR SUPPLIER CARE HEALTH CEN	TER		9:	TREET ADDRESS, CITY, STATE, ZIP CODE 32 BADDOUR PARKWAY EBANON, TN 37087	, 55,.	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	κ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
K 355 SS=D K 363 SS=D	Portable Fire Exting Portable fire extinguinspected, and main NFPA 10, Standard Extinguishers. 18.3.5.12, 19.3.5.12 This STANDARD is Based on observation and maintain the fire extinguisher of the Class K fire of the Class K extinguisher of 19.3.5.1 (2012 Edition) NFPA 10, 5 Maintenance staff with deficiencies were in acknowledged the conference on 03/2 NFPA 101 Corridor Corridor - Doors 2012 EXISTING Doors protecting correquired enclosures hazardous areas shas those constructe core wood, or capail 20 minutes. Doors in compartments are of passage of smoke, means suitable for least 19.3.5.1 (2012 EXISTING Doors protecting correquired enclosures hazardous areas shas those constructe core wood, or capail 20 minutes. Doors in compartments are of passage of smoke, means suitable for least 19.3.5.1 (2012 EXISTING Doors protecting correspondents are constructed to the correspondent and corr	guishers uishers are selected, installed, ntained in accordance with for Portable Fire 2, NFPA 10 s not met as evidenced by: tions, the facility failed to tinguishers. ed: 27/2017 at 10:03 AM, revealed extinguisher placard posted at isher (sign posted over the n a different wall). NFPA 101, ion) NFPA 101, 9.7.4.1 (2012 i.5.5.3 (2010 Edition) was present when the lentified and the administrator deficiencies during the exit 7/2017.	K 3		K355 - Portable Fire Extinguishers Corrective Action: The Class K fire extinguising has been moved by the Director of Maintenance to the location of the extinguisher. Identifying other residents that have the potential to be affected: The facility deter that any residents near or around the kitch the potential to be affected as residents at the kitchen. There is no other potential araffected by Class K fire extinguisher as the 1 in the facility, located in the kitchen. Measures and Systemic changes: The sign indicating the location of the Class K Fire extinguisher was moved by the Director of Maintenance to the location of the extinguisher was moved by the Director of Maintenance to the location of the extinguisher was moved by the Director of Maintenance to the location of the Sign will be checked by the designee 1x month x 3 months. The ADM designee will review the audits and report to the QAPI committee. The QAPI committee review the results at the QAPI meeting to each of the POC was effective and if any further conaction is warranted.	wisher. cation of mined nen have re not in ea to be re is only lisher. The ADM or or findings re will ensure	4/27/17

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY PLETED
		445154	B. WING			03/	27/2017
	PROVIDER OR SUPPLIER CARE HEALTH CEN	TER		93	TREET ADDRESS, CITY, STATE, ZIP CODE 32 BADDOUR PARKWAY EBANON, TN 37087	, 55,	
(X4) ID PREFIX TAG	EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FUIL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PI.AN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION UALE
	floor covering is not latches are prohibite corridor doors and or combustible mate complying with 7.2. devices that release pulled are permitted of unlimited height a meeting 19.3.6.3.6 and the smoke compart window assemblies sprinklered compart window assemblies sprinklered compart restrictions in area of frames in window as 19.3.6.3, 42 CFR Parand 485 Show in REMARKS protection ratings, and 485 Show in REMARKS protection ratings, and the findings included the findings included the corridor door of the findings included the corridor door of the findings included the corridor door of the door of 19.3.6.3.2 (2012 Edited Maintenance staff with deficiencies were identicated to the corridor door of the door of 19.3.6.3.2 (2012 Edited Maintenance staff with the corridor staff with the corrido	etween bottom of door and exceeding 1 inch. Roller and by CMS regulations on rooms containing flammable erials. Powered doors 1.9 are permissible. Hold open a when the door is pushed or 1. Nonrated protective plates are permitted. Dutch doors are permitted. Dutch doors are permitted. Eixed fire are allowed per 8.3. In the there are no or fire resistance of glass or seemblies. The arts 403, 418, 460, 482, 483, details of doors such as fire utomatics closing devices, and the facility failed to ors. d: 17/2017 at 11:27 AM, revealed the ICF kitchen dishwashing the passage of smoke (gap at ver ½ inch). NFPA 101, tion) as present when the entified and the administrator efficiencies during the exit	κs		K363 – Corridor – Doors Corrective Action: The corridor door of the kitchen dishwashing room has been repaire the Director of Maintenance and no longer greater than ½ inch to meet the resistance passage of smoke. Staff was inserviced by ADM or designee on checking smoke/fire didentifying other residents who have the potential to be affected: The facility has determined that any residents near or arould fitchen dishwashing room have the pot to be affected. Smoke doors will be checked Director of Maintenance or designee for the purpose of ensuring there is not a gap great 1/2." Measures or Systemic changes: Checking stoors was added to the Maintenance Checked be performed by the Director of Maintenance and any doors identified with a gap greater than 1/2." will be repaired by Direct Maintenance or designee. How corrective action will be monitored: Smoke/Fire doors will be checked by the AE designee monthly x 3 months. The ADM or designee will review the audits and report for the QAPI committee. The QAPI committee the POC was effective and if any further correction is warranted.	ed by has gap of the the cors. and the ential d by the e ter than moke klist to ice or p tor of	4/27/17

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG 01 - MAIN BUILDING 01		E SURVEY IPLETED
		445154	B. WING_		03/	27/2017
	PROVIDER OR SUPPLIER TY CARE HEALTH CEN			STREET ADDRESS, CITY, STATE, ZIP CODE 932 BADDOUR PARKWAY LEBANON, TN 37087	1 00/	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUSY BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOU). CROSS-REFERENCED TO THE APPROVIDENCY)	BE	(X5) COMPLETION DATE
K 364 K 364 SS=I	NFPA 101 Corridor Corridor - Opening Transfer grilles are doors. Auxiliary sp flammable or comb to have louvers or In other than smok patient sleeping rot are permitted in vis the openings per ro inches and are at o floor to ceiling. In s per room do not ex Vision panels in co fixed window asser fully sprinklered sm no restrictions in th glass and frames.) 18.3.6.5.1, 19.3.6.5 This STANDARD i Based on observa maintain the corridor The finding include Observation on 3/2 transfer grill in the A	ropenings not used in corridor walls or paces that do not contain pustible materials are permitted be undercut. e compartments containing oms, miscellaneous openings ion panels or doors, provided from do not exceed 20 square or below half the distance from prinklered rooms, the openings ceed 80 square inches. Indication walls or doors shall be inapproved frames. (In toke compartments, there are a area and fire resistance of i.2, 8.3 is not met as evidenced by: tions, the facility failed to or openings.	K 36	•	sfer grill. rmined VB ected. tor of s. ed by The the QAPI	4/27/17
K 511 SS=D	deficiency was iden by the administrator 3/27/17. NFPA 101 Utilities -		K 51	1		
	f			I .		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENT/FICATION NUMBER:	Atolical distribution in Adaptive research		(X3) DATE SURVEY COMPLETED		
		445154	B. WING		02/27/204-		
NAME OF PROVIDER OR SUPPLIER QUALITY CARE HEALTH CENTER			L	9	TREET ADDRESS, CITY, STATE, ZIP CODE 32 BADDOUR PARKWAY EBANON, TN 37087	1 03/	27/2017
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (FACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
K 511	Continued From page 12 Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2		K	511	K511 – Utilities – Gas and Electric Corrective Action: The junction boxes outside rooms 103, 99 and 111 have been repaired and are recessed in the wall by a contractor. Identifying other residents who have the potential to be affected: The facility determined that all residents have the potential to be affected. Junction boxes will be checked by the Director of Maintenance or designee to ensure they are completely recessed in the wall. Measures or Systemic Changes: Any junction boxes identified not completely recessed in the		4/27/17
	Based on observational maintain the utilities. The findings includes. 1. Observation on 0 and 10:26 AM, revecorridor (fire alarm installed properly (pthe following locational outside room 1: 0. Outside room 1: NFPA 101, 19.5.1.1	ed: 3/27/2017 between 10:13 AM aled the junction boxes in the ndicating devices) were not artially recessed in the wall) in as: 03	de Ho Q/ m		well will be repaired by Director of Mainter designee or contractor if warranted. How corrective action will be monitored: QAPI committee will review the results at to meeting to ensure the POC was effective at further corrective action is warranted.	he ne QAPI	
K 741 SS=D	Maintenance staff w deficiencies were ide acknowledged the d conference on 03/27 NFPA 101 Smoking Smoking Regulations Smoking regulations	entified and the administrator eficiencies during the exit 7/2017. Regulations	K 7	41	·		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/31/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCES				OMB NO. 0938-0391					
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (C1)		(X1) PROVIDER/SUPPLIER/CLIA IDENT/FICATION NUMBER:	I ' '	MULTIPLE CONSTRUCTION UILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED		
NAME OF	DUMANTO OU CURNIER	445154	B. WING		***	03/:	27/2017		
NAME OF PROVIDER OR SUPPLIER QUALITY CARE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 932 BADDOUR PARKWAY LEBANON, TN 37087						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION)			ΙX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE		
K 741	(1) Smoking shall be ward, or compartme combustible gases, and in any other haz area shall be posted SMOKING or shall international symbol (2) In health care of prohibited and signs major entrances, se that prohibits smoking (3) Smoking by patteresponsible shall be (4) The requirement where the patient is (5) Ashtrays of nono design shall be provided by smoking is permitted (6) Metal containers devices into which a be readily available to permitted. 18.7.4, 19.7.4 This STANDARD is Based on observation force smoking regions of the finding included Observation on 3/27.	e prohibited in any room, ent where flammable liquids, or oxygen is used or stored zardous location, and such if with signs that read NO be posted with the lifer no smoking. Ecupancies where smoking is are prominently placed at all condary signs with languageing shall not be required. Ents classified as not prohibited. If of 18.7.4(3) shall not apply under direct supervision, combustible material and safe ided in all areas where it. With self-closing cover ishtrays can be emptied shall to all areas where smoking is not met as evidenced by: ons, the facility failed to julations.	К7	741	K741 - Smoking Regulations Corrective Action: Employee was counseled smoking in a non-smoking area by ADM. St were inserviced by ADM or designee that st is only permitted in designated areas. Identifying other residents that have the potential to be affected: The facility determination and the potential to be affected. Areas with flammable liquids, combustible gases, oxygen in use or stored any other hazardous location will be checked the Director of Maintenance or designee to there are No Smoking signs posted. Measures and Systemic Changes: Areas with flammable liquids, combustible gases, oxygen use or stored and any other hazardous location will be posted by Director of Maintenance or designee. How corrective action will be measured: The smoking area behind central supply will be monitored by ADM or designee 1x week x4 then monthly for 2 months. The ADM or dewill review audits and report findings to the committee. The QAPI committee will review results at the QAPI meeting to ensure the Preffective and if any further corrective action warranted.	aff noking nined ne area and d by ensure ere any en in tions the me non- weeks signee QAPI the OC was	4/27/17		
К 923	The maintenance dir deficiency was identi	rector was present when this ified and was acknowledged during the exit conference.	K 9:	23					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445154		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER		B. WING	_		03/	27/2017	
QUALITY CARE HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 932 BADDOUR PARKWAY LEBANON, TN 37087			-
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDUR'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUTH ACTION SHOUTH ACTION SHOUTH ACTION SHOUTH ACTION SHOUTH ACTION SHOUTH ACTION ACTI		BE	(X5) COMPLETION DAYE
K 923 \$\$=E	Gas Equipment - C Greater than or equ Storage locations a ventilated in accord 5.1.3.3.3. >300 but <3,000 cu Storage locations a within an enclosed limited- combustible gates outdoors) that gases are not store separated from con sprinklered) or encl noncombustible con 1/2 hr. fire protection Less than or equal in a single smoke of cylinders available to care areas with an a or equal to 300 cub stored in an enclose handled with precau A precautionary sign each door or gate of where the sign inclusing minimum "CAUTION STORED WITHIN IN Storage is planned and of which they are re Empty cylinders are cylinders. When far integral pressure gas considered empty is are marked to avoid in the open are prot 11.3.1, 11.3.2, 11.3.	cylinder and Container Storage lat to 3,000 cubic feet line designed, constructed, and lance with 5.1.3.3.2 and libic feet line outdoors in an enclosure or interior space of non- or eleconstruction, with door (or lit can be secured. Oxidizing d with flammables, and are inbustibles by 20 feet (5 feet if losed in a cabinet of instruction having a minimum in rating. los 300 cubic feet compartment, individual for immediate use in patient laggregate volume of less than lic feet are not required to be litered. Cylinders must be litions as specified in 11.6.2. In readable from 5 feet is on if a cylinder storage room, lides the wording as a N: OXIDIZING GAS(ES) NO SMOKING." so cylinders are used in order ceived from the supplier. I segregated from full cility employs cylinders with luge, a threshold pressure is established. Empty cylinders I confusion. Cylinders stored	K	923	<u> </u>	has ance od by the boxygen irector oM or gn ng orage ential to: ny i units oxygen tor of e. gen erlals ed or orage signee, orage signee, is, i report	4/27/17

Apr. 19. 2017 1:49PM Quality Center

No. 5459 P. 23

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
445154		B. WING			03/27/2017		
NAME OF PROVIDER OR SUPPLIER QUALITY CARE HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP O 932 BADDOUR PARKWAY LEBANON, TN 37087	ODE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF COI X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
K 923	maintain the oxyger The findings include Observation on 03// 10:18 AM, revealed feet of combustible locations: a. ICF oxygen stor (plastic cart and wo b. Skilled Unit oxy concentrators) NFPA 99, 11.3.2.3 (Maintenance staff w deficiencies were id	ions, the facility failed to a storage areas. 27/2017 between 9:46 AM and the oxygen storage within 5 materials in the following rage room 28 "E" cylinders od counter) gen storage room (oxygen 2012 Edition) vas present when the entified and the administrator deficiencies during the exit	Κ 9	DEFICIENCY)			